Dear Mileage Reimbursement Client,

Welcome to the mileage reimbursement program sponsored through the Medical Assistance Transportation Program. Please take time and review the enclosed paper work. I believe it will help you maximize the benefits that you can receive from the mileage reimbursement program.

Please fill out the paperwork as follows:

Intake Forms & Medical Assistance Eligibility Form:

- Fill out one form per client that has an active Medical Assistance card.

W-9:

- Fill out one form per adult that will be receiving mileage reimbursement check. This would be medical assistance client, if over 18 or parent/guardian if medical assistance client is under 18 or unable to make financial decisions.

Verification for Medical Assistance Medical Mileage:

- You must have one form filled out for each visit to medical facility or pharmacy.
- All signatures must be original; **no stamped signatures** will be accepted.
- Please fill out each submission form completely, including your original signature and mileage. Please make sure that your signature is legible. If you are unsure, print your name beside it.
- If the driver lives at a different address then the medical assistance client, then it is the client's address that you list on this form, not the driver's. Mileage reimbursement begins from the clients address.
- Please save one blank copy of the mileage form to make additional copies with.
- Do not cut forms in half. Forms that are cut in half will be returned to you.
- Please record mileage in whole numbers by rounding up or down.
- Please be aware that you have 7 days from the end of each month to submit your trip information to the Franklin County Transportation office for reimbursement. There is a black mailbox to the right of the Franklin County Transportation office that is available 24 hours a day and checked daily.
- All lines of the forms must be complete or they will be returned and delay payment. If a form is incomplete and in the process of returning it to you the submission month expires, the form may no longer be submitted. If your signature is unrecognizable, please print your name beside it. If the form or information on the form has been altered you may be required to obtain a new form or additional proof of treatment.
- Franklin County Transportation will no longer issue checks for less than $10.00. If your mileage check is less than $10.00, we will wait until you accumulate more miles before processing. This can only be done if your forms were submitted on time by the 7th of each month. If this creates undue hardship, please contact me directly and we can discuss your individual situation.
- **If more then one medical assistance client is traveling the same vehicle only one participant can claim mileage reimbursement for the trip. If a third party is transporting multiple clients to an appointment, mileage can only be claimed by one program participant. This program is to assist with recouping the cost of fuel not as income or for time or number of appointments. If you are not using a motorized vehicle to transport to medical appointments then you may not claim mileage. If you receive care at multiple locations with in the same area at the same time, you can only claim mileage for one of the trips. Any fraudulent submissions will not be paid and forwarded to the Inspector General's office for investigation.**
- If you are transported to your medical care by Franklin County Transportation or Franklin County employee, Touch of Life, American Cancer Society, or other non-profit volunteers, then you cannot claim mileage reimbursement.
- If you are submitting proof of tolls and parking, please tape or glue receipts flat on a blank sheet of paper. Receipts that are not secured will be returned.

Thank-you & welcome to the program!

Cindy Blackstock
MATP Coordinator
717-264-5225 X 4

Mileage Reimbursement Facts:

Who qualifies for mileage reimbursement?
Any Franklin County Resident who has an active medical assistance card issued by the County Board of Assistance office. You can receive mileage reimbursement whether you are transporting yourself or being driven by another individual. The program also applies to the transportation of children who have a valid medical assistance card and are receiving medical treatment. Reimbursement only applies to **1** person per vehicle if multiple passengers have the medical assistance card.

What is mileage reimbursement?
If you have a medical assistance card, we can reimburse you $ x.12 per mile for transportation costs to and from medical appointments that are being billed to the medical assistance card. The program also applies to the transportation of children who have a valid medical assistance card and are receiving medical treatment.

What kind of services does mileage reimbursement cover?
Visits to the doctors, dentists, therapists, psychologist, psychiatrist, physical therapy, tolls/parking (with original receipt) and to the pharmacy (prescription drugs only) that are billed to your Medical Assistance card.

Are there restrictions to where I can go and still receive reimbursement?
You can apply for reimbursement for local and long distance trips to medical appointments that are billed to the PA Medical Assistance card. If a trip is out of State or are over more then 400 miles or 4 hours travel one way please get pre approval. Please be advised that you must use one of the two closest pharmacies near to your home or one of the two closest to your doctors (this is only applicable when the prescription is in conjunction with a medical visit.) If you are claiming mileage for a pharmacy, please wait for the prescription to be filled and if at all possible, consolidate prescription pick ups to decrease unnecessary mileage.

What if I have a question about my mileage reimbursement?
If you have a question about how to submit your mileage reimbursement forms or about a current submission, call the Franklin County Transportation Office at 717-264-5225 X 7.

Can I just stop in at the transportation office if I have questions?
In order to serve your needs better, we advise that you call and speak with the MATP coordinator to schedule an appointment. By doing this, you allow us a chance to research your question and may even save you the trip. Ninety-five percent of questions and concerns can be answered over the telephone.

Why do I have to get an original signature?
An original signature is required because it is validation that you received the service that you are submitting mileage reimbursement for.

When do I hand in my mileage reimbursement forms?
All forms for the each month are due by the 7th of the following month. For example: All mileage forms for November must be received by Franklin County Transportation by 9:00 am on December 7th. Likewise all mileage forms for December must be received by Franklin County Transportation by 9:00 am on January 7th. If the 7th is a weekend day or holiday then forms will be due by 9:00 am on the following business day. Submissions for the previous month will not be accepted after that 7th of each month. Please note that the drop off box is available 24 hours a day, 7 days a week. In addition, if mailed on the 1st of each month forms should arrive by the 7th. If there are mistakes it is your responsibility to correct the forms in a timely manner or there may be a delay or denial of payment. Checks will be processed and mailed out by the by the last day of each month. If you do not receive your check by the 7th of the next month, please contact us. Please, do not contact the Controllers Office about your payments until 30 days past the processing date

Is this taxable income?
Be advised that **ALL** medical mileage reimbursements paid over the IRS allowable rate is taxable income to those receiving the payments and must be reported to IRS on Form 1099 Miscellaneous. Please refer to the http://www.irs.gov/ for current rates.

FRANKLIN COUNTY MILEAGE REIMBURSEMENT INTAKE
DATE____/___/____

Social Security Number Birth Date Age

_____-_____-_____ _____/_____/_____ _____

Phone #_____Secondary phone #_____

Name: _____, _____
(Last) (First)
Address: _____

Apt. /Lot #: _____City_____ZIP_____

Medical Assistance #: _____
Issue Date: _____

Mobility: (Check)
Ambulatory ___ Braces___Cane___Walker___Crutches___

Service Animal___Type_____

Wheelchair ____ Electric____ Oversized Wheelchair____ Scooter___ Ramp_____
Is your ramp made according to the ADA specifications? One inch per foot_____

Please include the names of any other household/family members who are participating in the mileage reimbursement program:
_____
_____
_____

Please list any transportation programs that you receive services or transportation from?
_____
_____

Vehicle Make & Model _____ Plate # _____
Vehicle Make & Model _____ Plate # _____

Provide your license number and expiration date for yourself and any person transporting you.
Name:_____ Lic # _____ Exp date:_____
Name:_____ Lic # _____ Exp date:_____
Name:_____ Lic # _____ Exp date:_____
Name:_____ Lic # _____ Exp date:_____

Complete the following sections only:
Section 1, Section II (recipient #, soc sec #), Section V (sign and date)

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM ELIGIBILITY FORM

SECTION I - HOUSEHOLD IDENTIFYING INFORMATION

NAME (Last, First, MI)	DATE OF BIRTH	TELEPHONE NUMBER
ADDRESS (Street, City, Town, State, Zip Code)		COUNTY OF RESIDENCE

SECTION II - MEDICAL ASSISTANCE ELIGIBILITY VERIFICATION/REVERIFICATION

MATP FUNDING STATUS ▶ ☐ GROUP I ☐ GROUP II (D-00, D-05, B-00, PD-00, PD-21, PD-22, TD-00, TD-11, TB-00)

ACCESS CARD INFORMATION ▶	RECIP NUMBER	SOCIAL SECURITY NUMBER	CARD ISSUE NO.

EVS ELIGIBILITY INFORMATION					
	DATE OF SERVICE				
	HEALTH CARE BENEFIT CODE				
	PROGRAM STATUS CODE				
	CATEGORY OF ASSISTANCE				
COMPLETED BY:	PLAN NAME				
	HOTLINE NUMBER				
	LOCK IN INFO				

OTHER ELIGIBLE HOUSEHOLD MEMBERS

NAME	RECIPIENT NUMBER	SSN	STATUS	DOB	GRP	MODE	FREQ/Wk-Mo	SPEC. NEED

MODE KEY ▶ P = Public Transit S = Shared Ride A = Private Auto V = Volunteer O = Other (See Svc. Notes)

SECTION III - DETERMINATION OF NEED FOR SERVICES

OTHER FUNDING SOURCES ▶ ☐ PENNDOT 203 ☐ DEPARTMENT OF AGING ☐ OTHER (Explain) _____

SPECIAL NEEDS ▶

MODE ▶

OTHER INFORMATION/ SERVICE NOTES ▶

SECTION IV - ELIGIBILITY DETERMINATION DECISION

ELIGIBILITY STATUS ▶ ☐ ELIGIBLE ☐ INELIGIBLE | DATE CLIENT NOTIFIED ▶ | DATE ELIGIBILITY DETERMINED ▶

INELIGIBLE (Explain)

SECTION V - AFFIRMATION OF INFORMATION

I hereby certify, that, to the best of my knowledge, the information contained herein is true, correct and complete. I agree to report any changes in circumstances immediately to this Service Provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Public Welfare fair hearing. This affirmation statement covers all attachments required for the determination of eligibility.

SIGNATURE OF CLIENT OR DESIGNEE	DATE SIGNED*	SIGNATURE OF INTERVIEWER	DATE SIGNED*

00502A